IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CHRISTOPHER FOSTER,	:	
	:	
Plaintiff,	:	
	:	
v.	:	
	:	
CITY OF PHILADELPHIA,	:	
and	:	
PHILADELPHIA POLICE DEPARTMENT ,	:	
and	:	
POLICE CORRECTIONAL OFFICER,	:	
SHELDON MOORE, BADGE #133	:	
and	:	
IRA WATTERSON, EMPLOYEE	:	
OF CITY OF PHILADELPHIA,	:	
and	:	
FELISA MASSEY, EMPLOYEE	:	CIVIL ACTION
OF CITY OF PHILADELPHIA,	:	
and	:	
ROBERT OTTO, EMPLOYEE	:	
OF CITY OF PHILADELPHIA,	:	
and	:	
PHILADELPHIA FIRE DEPARTMENT,	:	NO. 01-CV-3810
and	:	
PHILADELPHIA POLICE OFFICER,	:	
JOHN OR JANE DOE, BADGE #4946,	:	
and	:	
PHILADELPHIA POLICE OFFICER,	:	
JOHN OR JANE DOE, BADGE #1169,	:	
and	:	
PHILADELPHIA POLICE OFFICER,	:	
ANNAMAE LAW, BADGE #2734,	:	
and	:	
PHILADELPHIA POLICE OFFICER,	:	
JOHN OR JANE DOE, BADGE #2596,	:	
and	:	
SERGEANT MCGOWAN, BADGE #8611	:	
and	:	
CPL. RIZZO, BADGE #8107,	:	
	:	
Defendants.	:	

MEMORANDUM OPINION

Presently before the Court is Defendants' Motion for Summary Judgment (Dkt.No.17). For the reasons discussed below, Defendants' Motion is Granted in part and Denied in part.

I. Background

Plaintiff asserts 42 U.S.C § 1983 claims against the City of Philadelphia, the Philadelphia Police Department, the Philadelphia Fire Department and numerous employees of the City of Philadelphia Police and Fire Departments.[1] Specifically, Counts I, III, and IV raise state law negligence claims based on the care Plaintiff received while in police custody. Count II raises a claim for violation of Plaintiff's Fourteenth Amendment right to be secure in his life and person and to receive proper medical care while confined pursuant to state authority. Count V alleges a violation of Plaintiff's Eighth Amendment right to be free from cruel and unusual punishment allegedly caused by the City's failure to adequately train its employees as to the care of potentially suicidal detainees. In Count VII, Plaintiff alleges a violation of the Eighth Amendment proscription against cruel and unusual punishment, arising from the medical treatment Plaintiff received as a pretrial detainee. Finally, Count VI asserts a state law bad faith claim arising from medical care provided to Plaintiff while in custody.

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[1] Plaintiff has named the following City of Philadelphia employees as Defendants: Police Correctional Officer Sheldon Moore, Police Officer Ira Watterson, Police Correctional Officer Felisa Massey, Robert Otto, Police Officer Annamae Law, Police Officer Jane or John Doe, Badge # 2596, Police Officer Jane or John Doe, Badge # 4946, Police Officer Jane or John Doe, Badge # 1169, Police Sergeant McGowan, Badge # 8611, Police Corporal Rizzo, Badge # 8107.

All claims asserted against Jane Doe and John Doe Defendants are dismissed for failure to serve the summons and complaint within 120 days as required by Federal Rule of Civil Procedure 4(m). See Lynch v. Hunter, 2000 WL1793396, at * 1 (E.D. Pa. Nov. 22, 2000).

Defendants move for summary judgment on all claims. Defendants argue that Plaintiff's claims on Counts I, III, and IV are barred by 42 Pa. C.S.A. §§ 8541-8542, which grants immunity to the City of Philadelphia for most tort claims. With respect to Counts II, V, and VII Defendants assert Plaintiff cannot establish deliberate indifference to a known medical need. Finally, the City contends summary judgment should be granted as to Count VI because a bad faith cause of action is not cognizable under Pennsylvania common law.

The considerable record in this action reveals the following:

At approximately 12:30 a.m. on July 29, 1999, Defendant Police Officer Anna Mae Law ("Law") arrested Plaintiff, Christopher Foster ("Foster" or "Plaintiff"), age 22, on the misdemeanor charge of obstructing the highway. This offense, which is graded as either a summary or third degree misdemeanor, arises from blocking or obstructing vehicular traffic after police admonition. See 18 Pa. C.S.A. § 5507.

Upon arrest, Plaintiff was transported to the 26th Police District. (See Plaintiff's Memorandum of Law in Opposition to Defendants' Motion for Summary Judgment at 2; Dkt. No. 19; see also Defendants' Memorandum of Law in Support of Defendants' Motion for Summary Judgment at 1; Dkt. No. 17). At the 26th Police District, Robert Otto ("Otto") questioned Foster and completed the standard Detainee Medical Checklist Form (the "Medical Checklist")[2] for

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[2] The Medical Checklist, which is recorded electronically, contains thirteen questions relating to the health of detainees which are designed to permit city employees to assess and evaluate the health and safety of detainees. Specifically, the Medical Checklist provides:

> Does detainee have obvious pain or injury?
> Serious medical problems?
> Does s/he appear to be under the influence of alcohol/drugs?
> Does the detainee appear to be despondent/suicidal?
> Does the detainee appear to be irrational?
> Is the detainee carrying medication?
> Is this the first time you have been arrested?

Plaintiff. (Pl. Br., Exhibit F). The responses contained in this Medical Checklist indicate that Foster responded in the negative to each of the thirteen questions contained on the form. (Id.). Although Foster was confined in a standard cell in the 26th Police District, he was constantly in the presence of police personnel. (Defendant Law's Response to Plaintiff's Interrogatories Nos. 15, 24; Def. Br., Exhibit E).

A few hours later, Foster was transferred from the 26th Police District to the Front and Westmoreland Police District. (Id., at Response 16.) At Front and Westmoreland, Officer Livingstone ("Livingstone") interviewed Foster and completed a new Medical Checklist Form.[3] At that time, Foster answered "yes" to the question "[h]ave you ever tried to kill or harm yourself? (Defs.' Br. at 1; Defendant Law's Response to Plaintiff's Interrogatories No. 6). As a result of this response, Foster was placed in the plexiglass suicide watch cell. (Id.).

After several hours at the Front and Westmoreland Police District, Foster was transferred to the East Detectives Division. At East Detectives, Police Officer Ira Watterson ("Watterson") interviewed Foster and completed a third Medical Checklist. (Pl. Br. Exhibit D). At that time, Foster answered "yes" to the question "[h]ave you ever tried to kill or seriously harm yourself?," and acknowledged that he was presently taking medication. (Id.) Watterson made the following

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> Have you ever tried to kill or seriously harm yourself?
> Are you contemplating harming yourself now?
> Do you have any serious medical or mental problems?
> Do you have diabetes?
> Are you receiving any type of treatment?
> Is there anything else you should inform us of to endure your well being?

(Pl. Br., Exhibit D). Police personnel completing the medical checklist record the detainee's responses to a question in a "yes" or "no" fashion. Completed Medical Checklist forms are stored on the police department's city-wide computer system, ("PARS"), and are constantly accessible by authorized employees throughout the detention system. (Dep. of Watterson at 42-43, 99).

[3] Plaintiff did not name Police Officer Livingstone as a defendant.

notations in the "Remarks" section of the form: "1- valium" and "2-od on pills 5/96." (Id.) Foster's affirmative responses also prompted officers at East Detectives to place him in a suicide watch plexiglass cell.

In the very early hours of July 30,1999, Foster was transferred to the Police Detention Unit ("PDU") in the Police Administration Building ("PAB"). (Id. at 2) Although Foster's personal property and the paperwork relating to his arrest and confinement were transferred to the PDU,[4] receiving officers were not verbally notified that Foster had been placed on suicide watch earlier in his detention. (Id. at 2). Upon Foster's arrival at the PDU, Police Correctional Officer Felisa Massey ("Massey") reviewed his paperwork, including the Medical Checklists generated earlier in Foster's incarceration. (Dep. of Massey at 100). From a review of this file, Massey learned that Foster had previously advised other officers that he tried to kill or seriously harm himself in 1996. (Id. at 67, 70). Thereafter, Massey prepared another Medical Checklist for Foster. Plaintiff, once again, acknowledged a prior suicide attempt and informed Massey that he was presently under the influence of medication. The form completed by Massey records, for the first time, that Foster expressed a present desire to harm himself. (Id. at 59).

At approximately 8:00 a.m., Police Correctional Officer Sheldon Moore ("Moore") removed Foster from his cell at the PDU for his arraignment, which was conducted via closed circuit television. (Defs.' Br. at 4). After his arraignment, Moore returned Foster to the standard cell. (Pl. Br., Exhibit G). Moore testified that, shortly after placing Foster in the cell, Foster requested his medication and another sandwich. (Id.). Moore further testified that he explained to Foster that he would have to await the nurse's arrival in order to receive medication.

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[4] Foster's file included his previously created Medical Checklists and the Complaint or Incident Report prepared by Officer Law. (Defs.' Br. at 2).

Approximately one hour later, Foster hanged himself with his shirt from the bars on his cell door. (Dep. of Moore at 61-62)

Upon learning of Foster's suicide attempt, Officer Moore opened the cell door to approach Foster, and instructed Officer Lewis to summon the PAB paramedic. (Dep. of Moore at 63). Moore then entered the cell, lifted Foster and untied the shirt from around Foster's neck. (Id.). The paramedic used a device to open Foster's airway and Police Corporal Joseph Rizzo ("Rizzo") started CPR compressions. (Pl. Br., Exhibit G). When Rizzo tired, Officer Tyrone Parker ("Parker") continued the CPR compressions. (Id.) Moore testified that when the Fire Department Rescue Unit arrived, the PAB paramedic informed Fire Rescue they had been performing CPR for approximately eight minutes. (Id.). Fire Rescue transported Foster to Thomas Jefferson University Hospital.

Foster sustained severe permanent injuries and lapsed into a coma. (Compl. ¶ 22). On March 27, 2001, the Social Security Administration approved Plaintiff's claim for total disability. At the time the instant action was filed, Foster remained in a coma and was hospitalized in a nursing home. (Id.)

II. Standard of Review

Summary judgment is appropriate when "there is no genuine issue of material fact and . . . the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); see also Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). In reviewing the record, "a court must view the facts in the light most favorable to the nonmoving party and draw all inferences in that party's favor." Armbruster v. Unisys Corp., 32 F.3d 768, 777 (3d Cir. 1994). The moving party bears the burden of showing that the record discloses an absence of genuine issues as to any material fact and that he is entitled to judgment as a matter of

law. See Fed. R. Civ. P. 56(c); see also Adickes v. S.H. Kress & Co., 398 U.S. 144, 157, 106 S.Ct. 2505, 91 L.Ed.2d. 202 (1970). Once the moving party has met its burden, the non-moving party must go beyond the pleadings to set forth specific facts showing that there is a genuine issue for trial. See Fed. R. Civ. P. 56(e); see also Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 585-86, 106 S.Ct. 1348, 89 L.Ed.2d. 538 (1986). There is a genuine issue for trial "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." Anderson, 477 U.S. at 249. "Such affirmative evidence – regardless of whether it is direct or circumstantial - must amount to more than a scintilla, but may amount to less (in the evaluation of the court) than a preponderance." Williams v. Borough of W. Chester, 891 F.2d 458, 460-61 (3d Cir. 1989).

III. Counts I, III and IV

Defendants move to dismiss Count I, III, and IV of the Complaint, asserting that they are immune from laibility under the Political Subdivisions Tort Claims Act. Plaintiff contends each of his claims allege willful misconduct and are exempt from the Political Subdivisions Tort Claim Act. (Pl. Br. at 23 n.12). A review of Counts I, III, and IV reveals that each raises only state law negligence claims. The terms "negligence" or "negligent" permeate each of the Counts; language relating to willful conduct is absent. Absent a waiver by the City of Philadelphia, Defendants are immune from suit pursuant to the provisions of 42 Pa. C.S.A. §§ 8541-8542. The waiver of immunity extends only to eight narrow categories of negligence claims, none of which apply to the present matter. See 42 Pa. Cons. Stat. Ann. §§ 8541-42 (West 1998); see also Sameric Corp. of Delaware, Inc. v. City of Philadelphia, 142 F.3d 582 (3d Cir. 1998). Summary judgment is granted as to Counts I, III, and IV.

IV. Count VI

Count VI asserts a claim for bad faith based on the care Plaintiff received while in state custody. Defendant argues that no such cause of action exists under Pennsylvania common law. Plaintiff does not dispute Defendants' contention in his brief. Where a party makes no more than a single mention of a claim, the claim is consequently waived. National R.R. Passenger Corp. v. Pennsylvania Public Utility Com'n, 342 F.3d 242, (3d Cir. 2003) (holding that where a party failed to adequately brief an issue, it consequently waived that claim) (citing Reynolds v. Wagner, 128 F.3d 166, 178 (3d Cir.1997)); see also Warren G. v. Cumberland County Sch. Dist., 190 F.3d 80, 84 (3d Cir.1999) (issue waived if not raised in party's opening brief). Plaintiff makes no mention of his bad faith claim beyond its assertion in the Complaint, therefore the Court is not bound to consider its merits and the claim is waived. Accordingly, summary judgment is granted as to Count VI.[5]

V. Counts II, V and VII

In Counts II, V, and VII, Plaintiff asserts civil rights claims against numerous City of Philadelphia employees and the City of Philadelphia. Plaintiff's claims against Philadelphia Police Officers Law, Otto, Watterson, Massey and Moore arise from care and treatment rendered prior to the suicide attempt.[6]

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[5] Defendants' move for summary judgment as to the Philadelphia Police Department and the Philadelphia Fire Department pursuant to 53 P.S. § 16257, which prohibits civil actions against any department or division of the City of Philadelphia. Plaintiff concurs with the grant of summary judgment as to these defendants. (Pl. Br. at 3). Defendants' motions on all claims against the Philadelphia Police Department and the Philadelphia Fire Department are granted.

[6] The care provided by Officer Moore following Plaintiff's suicide attempt is discussed, infra, at 14-16.

A. Standard of Review

It is clearly established that the suicide of a pretrial detainee can support a recovery under § 1983. See Colburn v. Upper Darby Township, 946 F.2d 1017, 1023 (3d Cir. 1991) ("Colburn II"); see also Williams v. Borough of W. Chester, 891 F.2d 458 (3d Cir. 1989); Freedman v. Allentown, 853 F.2d 1111 (3d Cir. 1988). In order to establish liability under § 1983 in prison suicide cases, a plaintiff must prove: (1) the detainee has a "particular vulnerability to suicide," (2) the custodial officer or officers knew or should have known of the vulnerability, and (3) those officers "acted with reckless indifference" to the detainee's particular vulnerability. See Colburn v. Upper Darby Township, 838 F.2d 663 (3d Cir. 1988), *cert. denied*, 489 U.S. 1065, 409 S.Ct. 1338, 103 L.Ed.2d. 808 (1989) ("Colburn I"). To prevail, plaintiff must demonstrate "[a] level culpability higher than a negligent failure to protect from self-inflicted harm." Colburn II, 946 F.2d at 1024.

To demonstrate a "particular vulnerability to suicide," plaintiff must present affirmative evidence from which a reasonable jury could conclude that a "strong likelihood" exists that self-inflicted harm will occur. The "mere possibility" of self-inflicted harm is insufficient. Id. (quoting Torraco v. Maloney, 923 F.2d 231, 236 (1st Cir. 1991)). Moreover, even where a strong likelihood exists, the plaintiff must establish that the custodial officials "knew or should have known" of that strong likelihood. Colburn II, 946 F.2d at 1024. Whether the custodial officials "knew or should have known" can be demonstrated when the officials have "actual knowledge of an obviously serious suicide threat, a history of suicide attempts, or a psychiatric diagnosis identifying suicidal propensities." Id. at 1025 n.4 (citations omitted). "The 'strong likelihood' of a suicide must be 'so obvious that a lay person would easily recognize the necessity for

preventative action." Id. (quoting Monmouth County Correctional Inst. Inmates v. Lanzaro, 834 F.2d 326 (3d Cir. 1987) (citations omitted)).

1. Officers Law, Otto, Watterson and Moore

Because the claims against Law, Otto, Watterson, Massey and Moore concern acts and omissions that occurred before Foster's attempted suicide, Colburn II governs. Specifically, each of these Defendants urge the Court to grant summary judgment because Plaintiff has failed to adduce evidence that they: (1) knew or should have known of Foster's suicidal vulnerability or (2) acted with reckless indifference to that vulnerability either before or after his suicide attempt. (Defs.' Br. at 20).

2. Officer Law

The record establishes that Law, the arresting officer, was aware that Foster had been placed on suicide watch while confined in the Front and Westmoreland Police District. (Defs.' Br. at 1; Defendant Law's Response to Plaintiff's Interrogatories No. 6). Officer Law was also aware that Foster acknowledged a prior suicide attempt to interviewers at Front and Westmoreland. (Id. at No. 16). Evidence therefore exists from which a reasonable jury could fairly conclude that Officer Law had actual knowledge of Foster's suicidal vulnerability.

The record, however, is bereft of facts from which a reasonable jury could conclude that Officer Law acted with reckless indifference to this suicide vulnerability. Law simply arrested Plaintiff and transported him to the 26th Police District where he remained with other police personnel at all times. (See Defendant Law's Response to Plaintiff's Interrogatories No. 24). Law was not responsible for monitoring Plaintiff's physical safety while confined in the 26th District, or at any other phase of his confinement. These limited facts do not support a reasonable conclusion of reckless indifference to Foster's vulnerability to suicide. Indeed, Plaintiff's expert

agrees that Law did not act with reckless indifference. (Report of Dr. Fosen, February 3, 2003, at 10-14). As no reasonable jury could find that Law acted with reckless indifference to Foster's suicidal vulnerability, summary judgment is granted as to all claims asserted against Officer Law.

3. Robert Otto

Robert Otto completed Foster's medical checklist at the 26th Police District. At that time, Foster answered "no" to every question. (Pl. Br., Exhibit B). Plaintiff has adduced no evidence from which a reasonable jury could conclude that Otto knew or should have known that Foster had a particular vulnerability to suicide. Defendant's Motion for Summary Judgment is granted as to all claims against Robert Otto.

4. Police Officer Ira Watterson

Police Officer Ira Watterson interviewed Foster at East Detectives and completed Plaintiff's Medical Checklist. (Pl. Br., Exhibit D). At that time, Plaintiff stated he had previously tried to kill himself and that he was presently taking medication. (Id.) Watterson made the following additional notations on the Medical Checklist: "1- valium" and "2-od on pills 5/96." (Id.). Under these circumstances, a reasonable jury could properly find that Watterson knew of Plaintiff's heightened vulnerability to suicide.

Based upon the responses Plaintiff provided to Watterson, Foster was placed on suicide watch for his entire period of confinement at East Detective Division. (Pl. Br. at 23 n.11). Thus, the record fails to support any inference that Watterson neglected the elevated suicide risk presented by Plaintiff. No facts are presented from which a reasonable jury could conclude that Officer Watterson acted with reckless indifference as to Plaintiff's physical safety. Once again, Plaintiff's expert acknowledges the absence of facts to support an inference of reckless indifference to known medical needs. (Report of Dr. Fosen, February 3, 2003, at 10-14).

Accordingly, summary judgment is granted with respect to the claims asserted against Officer Watterson.

5. Officer Massey

Police Officer Massey completed Plaintiff's final Medical Checklist form at the PAB. Defendant Massey contends that the record fails to establish Foster's particular vulnerability to suicide and, even if a heightened vulnerability existed, Massey neither knew nor should have known of this increased risk. (Defs.' Br. at 20).

Plaintiff has established sufficient facts upon which a reasonable jury could conclude that Foster presented a heightened risk of suicide. In the Medical Checklists prepared at Front and Westmoreland and East Detective Division, Plaintiff acknowledged a suicide attempt in 1996, three years prior. Two of these checklists indicate that Plaintiff was under the influence of medication. (See discussion, supra., p. 3-4). In addition, the Medical Checklist completed by Massey evidences that Plaintiff articulated present thoughts of causing harm to himself. Additionally, Appendix E to the Police Department's Directive relating to "High-Risk Suicide Detainees" (See discussion, infra., p. 20-21), with which Massey should have been familiar, identifies a series of factors relevant to the identification of high risk detainees. At least five of these characteristics apply to Foster: use of drugs, young adult, arrested for a non-violent offense, previous suicide attempts and current thoughts of self-injury. Philadelphia Police Captain Robert Cleary, the supervisor of the PDU, testified that an affirmative answer to either the question relating to prior suicide attempts or the inquiry pertaining to current thoughts of self-harm should, standing alone, create a recognition of a heightened risk of suicide which must be addressed by specialized conditions of confinement. (Dep. of Cleary at 56, 76). Thus, a reasonable jury could conclude Plaintiff presented a heightened vulnerability for suicide.

Defendant contends Officer Massey neither knew, nor should have known, of this heightened vulnerability. At her deposition, Officer Massey testified that, upon Foster's reception into the PDU, she reviewed his file and discovered that he had previously informed police personnel of the 1996 suicide attempt. The same files revealed that Foster was medicated on valium. A careful review of the information available in Foster's electronic file should have revealed confinement in suicide prevention cells in two separate police districts earlier on the same day. Critically, in her own interview of Plaintiff, Massey recorded that Foster admitted that he was presently taking medication, that he had tried to kill or seriously harm himself in the past, and that he was currently contemplating harming himself. (Dep. of Massey at 59). As Captain Clearly testified, either a prior suicide attempt, or an expression of a present desire to cause harm to oneself, creates an increased risk of suicide. (Dep. of Cleary at 56, 76).

Defendant Massey maintains that "discovery in this matter has adduced no relevant evidence that a suicide attempt three years in the past creates a strong presumption that self-inflicted harm will occur." (Defs.' Br. at 20). This argument, however, fails to even consider the fact that Massey herself recorded that Foster admitted to *currently* contemplating harming himself, although she gave conflicting testimony on this issue at her deposition. Regardless of her subsequent testimony, that Massey recorded that Foster admitted to *currently* contemplating harming himself *alone* would permit a reasonable jury to find that she knew or should have known of Foster's suicidal vulnerability.[7] Viewing the evidence in a light most favorable to

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[7] With respect to the question "[a]re you contemplating harming yourself now?" Massey testified that, although she recorded that Foster answered "yes," in fact, he answered "no," and but that she made a keystroke error in recording his response in the computer. Whether Foster indeed made a keystroke error in completing Foster's Medical Checklist is also a genuine issue of material fact that is to be decided by the jury. Additionally, whether Foster's admitted suicide attempt 3 years prior placed Foster creates a "particular vulnerability to suicide" about which Massey knew or should have known is also a genuine issue of material fact that is to be decided

Plaintiff, and drawing all reasonable inferences accordingly, it is evident that a reasonable jury could find that Massey knew or should have know of Foster's particular vulnerability to suicide.

With respect to whether Massey "acted with reckless indifference" to Foster's particular suicidal vulnerability, given the strong evidence from which a reasonable fact-finder could infer knowledge of Foster's suicidal vulnerability, Massey's failure to take *any* preventative measure cannot be said to be constitutionally reasonable as a matter of law. Even a lay person would recognize the strong necessity for preventive action when confronted with a detainee on valium admitting to a prior suicide attempt to three separate police officers who also articulates a present desire to harm himself. Furthermore, because Massey's failure to act consistent with Police Department Directives on High-Risk Suicide Detainees (requiring communication of suicidal tendencies to the supervisor and all other police officials coming into contact with the detainee) could be found to be found to be a factor contributing to Foster's suicide attempt, Plaintiff has made the requisite causal nexus.

Viewing the evidence in the record in the light most favorable to Plaintiff, and drawing all reasonable inferences accordingly, it is evident that a reasonable jury could find that Massey's acts and omissions constituted reckless indifference. Therefore, Plaintiff has raised a triable issue of fact with respect to Massey. Summary judgment is denied as to the claims asserted against Massey.

6. Police Correctional Officer Moore

Police Correctional Officer Moore was on duty while Foster was detained at the PDU. As the officer directly responsible for monitoring the detainees, Moore interacted with Foster on several occasions during this detention. Specifically, Moore removed Foster from a PDU cell for

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by a jury.

his arraignment, returned Foster to the cell following his arraignment, had a conversation with Foster in which Plaintiff requested medication and a sandwich and, finally, observed Foster's behavior while conducting "walk-throughs" of the cellblock. (Pl. Br., Exhibit G). Although Moore was not specifically advised by any other officer that Foster presented an increased risk of suicide, a reasonable jury could find that Moore should have known of Plaintiff's increased risk of suicide based on his interactions with him during his detention at the PDU.

As a result of Officer Moore's contradictory statements with respect to the events that took place during Foster's detention at the PDU, a legitimate question of fact exists as to Moore's conduct during the period of Foster's confinement at the PAB. Specifically, Moore offered conflicting statements on the questions of whether Foster was placed in the cell with another inmate or whether another inmate was subsequently placed in the cell with him,[8] and whether Moore discovered Foster hanging when conducting a routine walk-through of the cellblock, or Foster's cellmate alerted Moore of the suicide attempt.[9] Moore's conflicting statements on these issues create disputed issues of material fact with respect to whether Foster was held in a cell with another inmate, whether Moore even conducted the required "walk-throughs" and the time intervals at which the "walk-throughs" were conducted, if, indeed, they actually occurred. These factual issues are critical to the summary judgment motion. If the "walk-throughs" were sporadic, or non-existent, a reasonable jury could conclude that the officer was recklessly

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[8] In an interview conducted shortly after Foster's suicide attempt, Moore stated that Foster was placed in the cell alone and subsequently another inmate was placed in the cell with him; however, at his deposition, Moore testified that, following his arraignment, he placed Foster in a cell where another inmate was already being held.

[9] In the investigative interview, Moore testified that Foster's cellmate alerted him to Foster's suicide attempt; however, at his deposition, Moore testified that he discovered Foster hanging while conducting a routine walk-through.

indifferent to a detainee presenting an increased propensity for suicide. Similarly, Plaintiff has raised a material question of fact as to whether Plaintiff, who acknowledged a previous suicide attempt and who articulated present thoughts of self-injury, was confined alone in a cell. These factual questions cannot be resolved at the summary judgment stage.

Because a reasonable jury could find that Foster's suicide attempt could have been prevented had Moore monitored Foster more closely, Plaintiff has made the requisite causal nexus. Summary judgment is denied with respect to the claims against Officer Moore arising from events prior to the suicide attempt.

7. Correctional Officer Moore, Sergeant McGowan and Corporal Rizzo

Plaintiff contends that Police Correctional Officer Moore, Sergeant McGowan and Corporal Rizzo were recklessly indifferent to Foster's known medical needs because, after Foster was discovered hanging from the bars of his cell, they failed to render prompt medical aid to Foster and failed to ensure that such aid was indeed rendered to Foster. (Compl. ¶¶ 36, 37).

When Foster was discovered injured in his cell, Moore loosened the shirt from around Foster's neck and removed him from a hanging position (Dep. of Moore Dep. at 67-68), Captain Rizzo administered CPR (Defendant Rizzo's Response to Plaintiff's Interrogatories No. 16), and Sergeant McGowan checked to make sure that aid was being rendered (Defendant McGowan's Response to Plaintiff's Interrogatories No. 16). Plaintiff fails to offer testimony or argument as to the perceived deficiencies in the medical treatment provided. The sparse record on this issue does not support a reasonable conclusion that either Moore, McGowan or Rizzo acted with reckless in difference to Foster's known medical needs. Accordingly, summary judgment is granted as to the claims asserted against Moore, McGowan and Rizzo based on the events that occurred after Foster's suicide attempt.

8. Claim Against the City of Philadelphia for Failure to Train

A municipality is liable for a constitutional tort only "when execution of a government's policy or custom, whether made by its lawmakers or by those whose edicts or acts may fairly be said to represent official policy, inflicts" a specific injury. See Robinson v. City of Pittsburgh, 120 F.3d 1286, 1295 (3d Cir. 1997) (quoting Monell v. Dept. of Social Services, 436 U.S. 658, 694, 98 S.Ct. 2018, 56 L.Ed.2d 611 (1978)); see also Miles v. City of Philadelphia, 2001 WL 34076644, at *10 (E.D. Pa. April 10, 2001). "Policy" is made when a decision maker with final authority to establish municipal policy with respect to the action in question issues an official proclamation, policy or edict. A "custom," of course, is conduct, which, although not formally authorized by law, reflects practices of state officials that are so permanent and well settled as to virtually constitute law. A "policy" is not limited to an edict or directive. Id. A single decision by an official with final discretionary decision making authority over the subject matter can constitute a "policy" if they have final discretionary authority to act with regard to the subject matter in question and deliberately choose a course of action from among various alternatives. See Pembauer v. City of Cincinnati, 475 U.S. 469, 481-84 (1986); Bello v. Walker, 840 F.2d 1124, 1129-30 n.4 (3d Cir. 1988).

"'Failure to train' claims are analyzed as a species of 'custom or practice' liability." Owens, 6 F. Supp. 2d at 387 (denying summary judgment on plaintiff's failure to train claim in a detainee suicide case). Section 1983 imposes liability for inadequate training when the police department's policies, customs, and directives establish reckless indifference to the rights of the persons with whom it come in contact. See City of Canton, Ohio v. Harris, 489 U.S. 378, 388 (1989). Though it may "seem contrary to common sense to assert that a municipality will actually have a policy of not taking reasonable steps to train its employees . . . it may happen that

in light of the duties assigned to specific officers or employees the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need." Id. at 390. Stated differently, "where a municipality's failure to train its employees in a relevant respect evidences a 'deliberate indifference' to the rights of its inhabitants . . . such a shortcoming [can] be properly thought of as a city 'policy or custom' that is actionable under § 1983." Id. at 389.

Accordingly, in order to successfully establish a failure to train claim regarding prison suicide, a plaintiff must: "(1) identify specific training not provided that could reasonably be expected to prevent the suicide that occurred; and (2) demonstrate that the risk reduction associated with the training is so great and so obvious that the failure of those responsible for the content of the training program to provide it can reasonably be attributed to deliberate indifference to whether the detainees succeeded in taking their lives." Colburn II, 946 F.2d at 1030; see also Owens, 6 F. Supp. 2d at 388.

Plaintiff challenges the adequacy of the City's training initiatives in specific areas relating to prevention of detainee suicide. Plaintiff contends § 1983 imposes liability upon the City for "deliberately failing to provide admittedly necessary training to its personnel that would have prevented Mr. Foster's hanging and subsequent brain injury." (Pl. Br. at 9). Specifically, Plaintiff contends, "to this day the City has provided only limited training to its employees regarding the risk of detainee suicides and how to detect and prevent them." (Id. at 5). "Police Corrections Officers working in the PDU receive only cursory training at the Police Academy," (Id.) and "are not trained that a suicide history requires special precautions, but instead, were left to exercise their own personal judgment as to whether a detainee's prior suicide attempt was

current enough to consider." (Id. at 6-7). Moreover, in Plaintiff's view, "police personnel should have been trained that a detainee's history of suicide automatically required placement in a suicide cell because of the obvious risk of a custodial suicide attempt, and that the fact of a detainee's prior placement in a suicide cell must be communicated within the detention system, and that the previous suicide cell detention must be maintained." (Id. at 9) Plaintiff's argument is therefore narrowly focused on the training actually provided in the areas of the identification of detainees with an increased risk of suicide and the reduction of the risk of suicide as to those individuals.

In response to this argument, the City broadly asserts: "The City of Philadelphia's policy and training is consistent with the constitutional mandate that detainees be protected from themselves. There is nothing facially unconstitutional about a policy and training that requires screening for potentially suicidal detainees through observation, communication, the use of the Detainee Medical Checklist questionnaire, and medical examination." (Defs.' Br. at 17). In support of this assertion, the City proffers numerous documents which delineate its written policy on screening for potentially suicidal detainees as evidence that its training is indeed constitutionally adequate. (See generally Defs.' Br. and Exhibits thereto)[10].

The following written Philadelphia Police Department policies relate to the detention conditions for detainees manifesting an elevated risk of suicide:

> 1. August 11, 1972: Philadelphia Police Department Directive 82 ("Directive 82") mandating that: (1) personnel remove any items a prisoner may use to harm himself before placement in a cell; and (2) prisoners potentially harmful to themselves should be placed in a cell with at least one other person whenever possible. (Dep. of Snock at 23).

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[10] Nowhere in its brief or in the supporting record does the City disagree with Plaintiff's assertions that City of Philadelphia policy-making officials knew of the increased risk of detainee suicide. (See generally Defs.' Br. and Exhibits attached thereto). Indeed, the City of Philadelphia's Exhibits included in the Defendant's Motion for Summary Judgment demonstrate a long-standing recognition of the increased risk of detainee suicide. (Id.) .

2. November 11, 1983: Appendix C to Directive 82 requires that supervisors and line officers inspect cellrooms at prescribed intervals. Prisoners requiring medication or medical care shall be taken to a hospital. (Id. at 24-25).

3. July 29, 1986: An amendment to Appendix C expands the list of items prohibited from possession by detainees on the cellblock and requires confiscation upon detection. This amendment requires supervisors to ensure that all prohibited items are removed from detainees. (Id. at 26-27).

4. May 20, 1994: This supplemental amendment to Appendix C directs police personnel to inform the detention unit supervisor and the cellroom attendant of any detainee statements or behaviors indicating the detainee is a danger to himself or others. This amendment also requires the monitoring of all inmates in "high risk" cells at five minutes intervals. (Id. at 27).

5. October 27, 1993: Appendix E to Directive 82, relating to "High-Risk Suicide Detainees," sets forth the policy for identifying and handling detainees at risk of harming themselves or others. Appendix E advises that suicide is the number one cause of death in jails and lock ups and that hanging is the predominant method used by suicidal detainees. (Pl. Br., Exhibit I). With respect to suicide prevention, Appendix E articulates certain of the characteristics and behaviors of high-risk suicide detainees. As written in Appendix E, the warning signs include:

*Recent, excessive drinking and/or use of drugs
*1st time arrestee
*Juvenile/young adult
*Arrested for non-violent offense (Misdemeanor/Summary)
*Noticeable behavior changes - may act calm once the decision is made to commit suicide - extreme anxiety/fear
*Recent loss of stabilizing resources - wife/loved one - job/school/home - finances
*Severe guilt or shame over the offense
*Same-sex rape or threat of it while in custody
*Previous suicide attempts or history of mental illness
*Poor health or terminal illness
*Talks about or threatens suicide
*Severe agitation or aggressiveness
*Projects helplessness/hopelessness - "No sense of future"
*May try to hurt self - attention-getting gestures
*Any other unbearable situation or combination of events
*Paranoid delusions and/or hallucinations

> *DEPRESSION - Depression is the most important factor indicating suicidal tendencies - extreme sadness, crying, withdrawal, lethargy, loss of self-esteem and blameworthiness are some of the characteristics exhibited by depressed individuals.

(See Appendix E). Appendix E cautions, however, that not all high-risk detainees exhibit the foregoing warning signs and instructs: "[I]t is imperative that the procedures specified in Directive 82 be closely followed in the handling of any detainee. Profiles do not predict and prevent all suicides. Police should safeguard against any injurious action by a detainee whether or not they display any of the [foregoing] factors." (Id.)

> 6. On October 26, 1995: A supplemental amendment to Appendix C was issued requiring a medical evaluation, in the form of the Detainee Medical Checklist for detainees entering any police facility and that detainees determined to be at risk for harming themselves or others shall be handled pursuant to the provisions of Appendix E. This amendment prohibits acceptance of a detainee from another holding facility unless a completed Medical Checklist is transmitted by the initial detention facility. Further, all detainee exhibiting possible suicide behavior are to be monitored every five minutes and if necessary, constantly. Finally, all cells are to be inspected for dangerous defects at the beginning of each tour. (Dep. of Snock at 27-28).

> 7. December 5, 2000: A further amendment to Appendix C set forth the Police Detention Unit's procedures for transferring emergency and non-emergency medical cases to the hospitals. (Id. at 20-21).

> 8. A portion of the Philadelphia Police Academy's written training materials addressing the issue of detainee suicide. (Defs.' Br., Exhibit Y).

> 9. Sections of the Philadelphia Police Department Advanced Training Unit's materials addressing the issue of detainee suicide prevention. (Defs.' Br., Exhibit Z).

A careful review of these materials reveals that the City of Philadelphia has promulgated policies and directives which appropriately recognize the increased risk of suicide among detainees. The City has also developed comprehensive written materials intended to reduce that risk. The issue, then, is whether the evidence submitted by the City, at this juncture, demonstrates, as a matter of law, that it provided constitutionally adequate *training* in the areas of the detection

of detainees with an increased risk of suicide and prevention of suicide with respect to those individuals.

Evidence of actual training is presented in two forms: the testimony of Captain Edward Cleary, the supervisor of the Police Detention Unit, regarding training practices, and the testimony of the individual defendants regarding the training they actually received.[11]

Captain Cleary testified that in-service training for police correctional officers is conducted once a year on all aspects of the operation of the PDU. (Defs.' Br., Ex. W. at 13-14). This training, which is conducted by the PDU lieutenant, "is about eleven hours. It's not much." (Id. at 14). Although Captain Cleary was not familiar with the specific elements of any of the annual in-service training programs,[12] he testified that it was his understanding that training concerning the screening of potential suicides in custody is included. (Id. at 14). Clearly also testified that Police Directive 82 and its appendices, which include the Medical Checklist Form, are the principal PDU

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[11] The Police Department's Advanced Training Unit's materials are provided without explanation. It is not clear which officials received the suicide prevention training reflected in the materials or whether the training even covered the time period relevant to the instant inquiry. Moreover, the materials, while detailed in many respects, include only a cursory reprinting of aspects of the Medical Checklist Form. The record is silent as to the specific components of the training provided on use of the medical questionnaire. (See generally Defs.' Br. and Exhibits attached thereto). No explanation is provided as to whether a prior suicide attempt or expression of current thoughts of self-injury warrant special treatment. These written policies and training protocols, standing alone, do not demonstrate that the City actually provided training to its employees.

[12] "Unless I look at the in-service training, I don't know that they were given that training. You're asking me to be very specific, and I only oversee the Police Detention Unit. I can't go line for line as to exactly what they do or don't do or how they're trained. I can say that as the commanding officer in overseeing that unit that they get trained in this form. Exactly what do the trainers cover in that form, I don't know. What did they say, how did they say it, I don't know. I can only say that they get training in how to fill this form out. I can't give you specifics it goes exactly this way, I can't do that." (Id. at 67).

training documents for suicide risk reduction. These directives are disseminated to employees with instructions to read and maintain them for reference purposes. (Id. at 25-26).

Captain Cleary offered the following testimony on the training with respect to the completion and interpretation of the Medical Checklist Form. First, neither the PDU manual (Id. at 37) nor the Medical Checklist contains instructions to guide interviewers on the appropriate response to affirmative questions. (Id. at 27-28). According to Cleary, this explanation should have been included in the PDU manual. (Id. at 37-38). Second, officers should have received training that any acknowledged prior suicide attempt should automatically result in placement in the high-risk suicide cell (Id. at 20-21, 25, 37-38, 56). Similarly, the expression of immediate thoughts of self-injury should mandate placement in the high-risk suicide cell. (Id. at 56, 76). Finally, Cleary testified that Philadelphia Police Department policy required employees from the initial holding facilities to verbally communicate to the receiving officers at the PDU the specific fact that Foster had been placed in a suicide cell earlier in his incarceration. While, in the view of Captain Cleary, this should have been an element of the City's training program (Id. 62-63; 68-69), Cleary was unable to locate documentation evidencing that such training had occurred. (Id. at 31-37).[11] Thus, the principal training official offered by the City on the issue of training provided few specific details about the relevant aspects of the suicide reduction training.

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[11] Lieutenant Doris, a supervisor at the PDU at the time of Foster's suicide attempt, also testified that information regarding a decision to place a prisoner in a suicide cell should have been passed on. (Dr. Fosen's Expert Report at 9). Neither party, however, included this lieutenant's deposition transcript in the summary judgment exhibits. Additionally, the City did not offer testimonial evidence from Police College officials as to nature and content of the suicide reduction training. Thus, significant gaps exist in the City's proof as to the content of the training program for suicide risk reduction for detainees. In effect, the City contends adequate training was provided, but fails to present the elements of the training program to the court for review.

The testimony of the officers who handled Foster during his detention is also relevant to the inquiry into the adequacy of the City's training as to handling detainees who are at a high-risk for suicide. Most officers generally testified that, upon commencement of employment, they received two weeks of training at the Police Academy**,** six months of on-the job training, and approximately eight additional hours in-service training annually. (Dep. of Massey at 88-89; Dep. of Parker 8-10). The content of this training was not otherwise described. Strikingly, one employee testified that he did not remember receiving the City's directive regarding screening detainees who may be at high-risk for suicide. (Dep. of Moore at 95). Massey testified that she was trained to monitor detainees on suicide watch at fifteen minute intervals; she was unaware that Appendix C required monitoring of detainees on suicide watch at five minute intervals. (Dep. of Massey at 76-79).

Also in conflict with the City's written policies, employees were not trained as to how to evaluate and assess whether a detainee would potentially harm himself while in custody, and that they thought they were to just use their own personal judgment in determining whether a detainee's prior suicide attempt warranted placement on "suicide watch." (Dep. of Massey at 69, 79, 106-7; Dep. of Parker at 21; Dep. of Moore at 85-87). Massey, for example, testified that a suicide attempt three years previous is not current, and therefore does not justify placement in a suicide prevention cell. (Dep. of Massey at 72-73, 104-105). Massey further testified she was not trained as to what constitutes a recent suicide attempt. In her view, "[t]his is common sense . . . that's just a judgment thing," and to her, a current suicide attempt meant "within a month or even six months, something real current." (Id. at 79). Massey further testified to her belief that "normally people who try to take pills are really not trying to kill themselves, they just want help."

(Id. at 104). Finally, Massey testified that she did not receive any training about how to assess information concerning a detainee's prior suicide attempt. (Id.)

Massey also failed to place Foster in a high-risk cell based on his acknowledgment of a prior suicide attempt and failed to communicate this information to her supervisor in violation of existing City policy. Most importantly, Lt. Doris, the supervisor at the PDU and training official for the police correction officers, testified that he "could not even begin to say whether it would be right or wrong in the PDU for a prisoner like [Foster] with a history of suicide attempts to be put in a suicide cell." (Dr. Fosen's Expert Report at 10). Finally, it does not appear that any of the officers involved in this episode followed City policy which required the direct oral communication of the fact that Foster had been placed in a suicide cell to officers subsequently assuming responsibility for detaining Plaintiff.

In conclusion, the record reveals that the City has proven the existence of comprehensive written policies regarding the handling detainees who are high-risk for suicide. The City, however, has offered insufficient evidence to refute the Plaintiff's contention that the content of the City's training program was *inadequate*. Owens, 6 F. Supp. 2d at 390 (citing Russo v. City of Cincinnati, 953 F.2d 1036, 1047 (6th Cir. 1992)) Thus, the adequacy of the content of the City's training program remains a disputed issue of material fact. See Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986). Inadequacy of training in the area of suicide detection and reduction may be viewed as "so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need." City of Canton, supra, at 388.

Even if it is assumed, however, that the City has met its initial burden, it is apparent that Plaintiff has provided sufficient evidence to permit a reasonable jury to find in his favor. See

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248-49 (1986); see also Owens, 6 F. Supp. 2d at 389. Plaintiff's expert states that the amount of training provided by the City of Philadelphia falls far below the national average: the City provides initial training for officers upon the commencement of their employment and then eight hours every year thereafter, while the national average is to provide 120 hours of training the first year and forty hours every year thereafter.

Moreover, Plaintiff's expert, Dr. Fosen, opined that officers at the PDU were not properly trained in suicide prevention measures. Specifically, Dr. Fosen's expert report noted that employees should have been specifically trained to appropriately react to a detainee's history of suicide as a trigger for placement in a suicide cell and constant and/or frequent five minute visual checks, and to ensure that the fact that a prisoner was placed in a suicide cell was verbally communicated to subsequent officers. Dr. Fosen further opined that the amount of in-service training that employees receive is inadequate, falling substantially below the national standard. (Pl. Br., Exhibit M).

Further, a plaintiff advancing a failure to train claim must show that the inadequacies in the training program bear a causal relationship to the ultimate injury. City of Canton, 489 U.S. at 391. The Supreme Court has instructed:

> [F]or liability to attach in this circumstance the identified deficiency in a city's training program must be closely related to the ultimate injury. . . . [The plaintiff] must still prove that the deficiency in training actually cause the [constitutional injury]. Would the injury have been avoided had the employee been trained under a program that was not deficient in the identified respect?

Id.; see also Owens, 6 F. Supp. 2d at 392-393.

The requisite causal nexus is present in the instant case. According to the City's policies, Christopher Foster's affirmative indications that he had attempted suicide three years prior should have resulted in placement in the suicide reduction cell. Similarly, Foster's expression of present

thoughts of self-injury should have resulted in confinement in the plexiglass suicide reduction cell. Finally, had officials at the PDU been notified that Foster was placed in suicide watch cells in two prior police districts during this incarceration, it is likely that Foster would have been placed in the PDU's suicide risk reduction cell. These variances from established City policies provide the requisite causal nexus.

On the whole, the record of this particular incident, viewed in a light most favorable to Plaintiff, as it must be on summary judgment, would support a fact-finder in drawing an inference that many of the officers involved failed to follow the City's policies. To be sure, the Supreme Court has cautioned against creating an inference of a failure to train from an isolated incident. "The existence of a patterns of tortious conduct by inadequately trained employees may tend to show that the lack of proper training, rather than a one-time negligent administration of the program or factors peculiar to the officer involved in a particular incident, is the 'moving force' behind the plaintiff's injury." Board of County Com'rs of Bryan County,Okl. v. Brown, 520 U.S. 397, 407 (1997). This record would amply support a conclusion by a reasonable jury that the performance shortcomings were a result of constitutionally inadequate training practices, and were not simply the result of isolated negligence.

Ultimately, however, the constitutional adequacy of the City's training program for suicide risk reduction among detainees is a matter for determination in light of all of the facts and circumstances presented at trial, when a full evidentiary record can be developed. At the summary judgment stage, however, the City has not established, as a matter of law, the absence of disputed issues of material fact as to the adequacy of the content of training programs for the identification and handling of high-risk potential suicidal detainees. Therefore, summary judgment must be denied.

VI. Conclusion

For the foregoing reasons, Defendants' Motion for Summary Judgment is GRANTED in part, and DENIED in part. An order follows.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CHRISTOPHER FOSTER,	:	
	:	
Plaintiff,	:	
	:	
v.	:	
	:	
CITY OF PHILADELPHIA,	:	
and	:	
PHILADELPHIA POLICE DEPARTMENT ,	:	
and	:	
POLICE CORRECTIONAL OFFICER,	:	
SHELDON MOORE, BADGE #133	:	
and	:	
IRA WATTERSON, EMPLOYEE	:	
OF CITY OF PHILADELPHIA,	:	
and	:	
FELISA MASSEY, EMPLOYEE	:	CIVIL ACTION
OF CITY OF PHILADELPHIA,	:	
and	:	
ROBERT OTTO, EMPLOYEE	:	
OF CITY OF PHILADELPHIA,	:	
and	:	
PHILADELPHIA FIRE DEPARTMENT,	:	NO. 01-CV-3810
and	:	
PHILADELPHIA POLICE OFFICER,	:	
JOHN OR JANE DOE, BADGE #4946,	:	
and	:	
PHILADELPHIA POLICE OFFICER,	:	
JOHN OR JANE DOE, BADGE #1169,	:	
and	:	
PHILADELPHIA POLICE OFFICER,	:	
ANNAMAE LAW, BADGE #2734,	:	
and	:	
PHILADELPHIA POLICE OFFICER,	:	
JOHN OR JANE DOE, BADGE #2596,	:	
and	:	
SERGEANT MCGOWAN, BADGE #8611	:	
and	:	
CPL. RIZZO, BADGE #8107,	:	
	:	
Defendants.	:	

ORDER

AND NOW, this day of January, 2004, it is hereby ORDERED as follows:

Defendants' Motion for Summary Judgment (Dkt. No. 17) is Granted in part, and Denied in part. More specifically:

1. The Motion for Summary Judgment is GRANTED as to the Philadelphia Police Department and the Philadelphia Fire Department. All claims asserted against these entities are DISMISSED;

2. The Motion for Summary Judgment is GRANTED as to all claims asserted against Defendants John or Jane Doe, Badge # 4946, John or Jane Doe, Badge # 1169, John or Jane Doe, Badge # 2734, and John or Jane Doe, Badge # 2596;

3. The Motion for Summary Judgment is GRANTED as to all Defendants with respect to the claims asserted in Counts I, III, IV, and VI. Counts I, III, IV, and VI are DISMISSED;

3. The Motion for Summary Judgment is GRANTED in part, and DENIED in part as to Counts II, V, and VII.

    a. The Motion is GRANTED as to all claims against Defendants Otto, Law, Watterson, Rizzo, and McGowan. All claims asserted against Defendants Otto, Law, Watterson, Rizzo, and McGowan are DISMISSED;

    b. The Motion is GRANTED as to all claims asserted against Defendant Moore arising from conduct following Plaintiff's suicide attempt.

    c. The Motion is DENIED in all other respects.

4. Counts II, V, and VII remain viable in their entirety as to the City of Philadelphia and Police Correctional Officer Felisa Massey. Counts II, V, and VII remain viable against Police Correctional Officer Sheldon Moore for claims arising from conduct prior to Plaintiff's suicide attempt.

BY THE COURT:

Legrome D. Davis, J.